DENTAL PROVIDER APPENDIX

Molina Medicare of Ohio

(MOLINA MEDICARE CHOICE CARE (HMO))

Medicare Advantage
2025

Capitalized words or phrases used in this Provider Appendix shall have the meaning set forth in your Agreement with Molina Medicare of Ohio. "Molina Medicare of Ohio" or "Molina" have the same meaning as "Health Plan" in your Agreement. The Provider Appendix is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Appendix at MolinaHealthcare.com.

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MEDICARE ADVANTAGE PRODUCTS

MOLINA MEDICARE CHOICE CARE (HMO)

Molina Medicare Choice Care (HMO) is Molina's Medicare Advantage and Prescription Drug plan designed for beneficiaries who are eligible for Medicare Part A and B. This plan offers all services covered by Original Medicare Parts A and B, prescription drug coverage, and more.

DENTAL SERVICES

The information contained within this Appendix is proprietary. The information is not to be copied in whole or in part; nor is the information to be distributed without the express written consent of Molina.
The Provider Appendix is a reference tool that contains eligibility, benefits, contact information, and policies/procedures for services that the Molina Healthcare of Ohio specifically provides and administers on behalf of Molina Members.
Molina is committed to improving our Members' health and making a difference in the communities we serve by overseeing:

- Primary and Specialty Care Dental Network
- Dental Network Management
- Quality Improvement
- Compliance Program (including fraud, waste, and abuse)

DELEGATION

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

1. Utilization Management
2. Credentialing and Recredentialing
3. Claims
4. CMS Preclusion List Monitoring
5. Other clinical and administrative functions

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and reviewed by Molina Delegation Oversight staff for compliance with performance expectations within the timeline indicated by Molina.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

CONTACT INFORMATION

Molina Medicare of Ohio
3000 Corporate Exchange Drive
Columbus, OH 43231

Provider Services

The Provider Services department handles telephone and written inquiries from Providers regarding address and Tax ID changes, contracting and training. The department has Provider Services Representatives who serve all of Molina's Provider network. Eligibility verifications can be conducted at your convenience via the SKYGEN Dental Hub.

- Phone: (855) 322-4079 (7 a.m. to 8 p.m. EST, Monday through Friday)
- SKYGEN Dental Hub: SKYGEN Dental Hub

Molina Dental Provider Services inquiries:

- MDVSProviderServices@MolinaHealthcare.com
- Phone: (855) 322-4079 (7 a.m. to 8 p.m. EST, Monday through Friday)
- Fax: (855) 297-3304

Provider Information Management Inquiries:

- MDVSPIM@MolinaHealthcare.com
- Phone: (855) 322-4079 (7 a.m. to 8 p.m. EST, Monday through Friday)
- Fax: (844) 891-2865

Member Services Department

The Member Services department handles all telephone and written inquiries from Medicare Members regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs) and Member complaints. This team will also offer to assist Members with obtaining Medicaid Covered Services and resolving grievances, including requesting authorization of Medicaid services, and navigating Medicaid appeals and grievances regardless of whether such coverage is in Medicaid fee-for-service or a Medicaid Managed Care Plan. Member Services Representatives are available Monday through Saturday, from 8 a.m. to 8 p.m., local time, excluding holidays. Eligibility verifications can be conducted at your convenience via the SKYGEN Dental Hub.

- Phone: (800) 642-4168
- Hearing Impaired (TTY/TDD): 711 Relay
- SKYGEN Dental Hub: SKYGEN Dental Hub

Claims Department

Molina strongly encourages participating Providers to submit Claims electronically (via a clearinghouse or the SKYGEN Dental Hub) whenever possible.

- Access the SKYGEN Dental Hub at SKYGEN Dental Hub.
- EDI Payer Identification (ID) number SKYGN.

To verify the status of your Claims, please use the SKYGEN Dental Hub. Claims questions can be submitted through the chat feature on the SKYGEN Dental Hub or contact Provider Services.

Claims Recovery Department

The Claims Recovery department manages recovery for Overpayment and incorrect payment of Claims.

Provider Disputes/Refund Checks	Molina Healthcare PO Box 641 Milwaukee, WI 53201
Phone	(855) 322-4079

Compliance/Anti-Fraud Hotline

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina AlertLine or submitting an electronic complaint using the website listed below. For more information about fraud, waste, and abuse, please see the Compliance section of this Provider Appendix.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

- Phone: (866) 606-3889
- Online: MolinaHealthcare.AlertLine.com

Credentialing and Recredentialing

Complete Section A and Section N of the Provider Information Form (PIF) Provider Information Form and include your Council for Affordable Quality Healthcare (CAQH) ProView ID # to credential the provider by returning the completed form via email to:

- mdvsproviderservices@molinahealthcare.com
- fax to 844-891-2865

CAQH must be re-attested within the last 4 months by visiting https://proview.caqh.org
Groups may attach a roster to their PIF with provider name, NPI and CAQH #.
Indicate "global" authorization which allows access to your data profile to all healthcare organizations.

Upload copies of your current DEA license and malpractice insurance copy directly to CAQH.
If you have questions regarding credentialing, please reach out to Molina Dental provider services via email at:

  - mdvsproviderservices@molinahealthcare.com
  - phone at 844-862-4564

Nurse Advice Line

This telephone-based Nurse Advice Line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, 365 days a year to assess symptoms and help make good health care decisions.

- English Line: (888) 275-8750
- Spanish Line: (888) 648-3537
- TTY/TDD: 711 Relay

Quality

Molina maintains a Quality Department to work with Members and Providers in administering the Molina Quality Programs.

- Phone: (855) 322-4079

PROVIDER RESPONSIBILITIES

Nondiscrimination in Health Care Service Delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of this Provider Appendix.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost sharing from a government-funded program.

Section 1557 Investigations

All Molina Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to Molina's Civil Rights Coordinator.

Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

- Toll Free: (866) 606-3889
- Hearing Impaired TTY/TDD: 711
- Online: MolinaHealthcare.AlertLine.com
- Email: civil.rights@MolinaHealthcare.com

Should you or a Molina Member need more information, you can refer to the Health and Human Services website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, Equipment and Personnel

The Provider's facilities, equipment, personnel, and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider Data Accuracy and Validation

It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Members and Provider Network.

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA) required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate their Provider information on file with Molina at least once every 90 days for correctness and completeness. Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes as soon as possible, but at a minimum of 30 calendar days in advance of the change of changes in any Provider information on file with Molina. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition of a Provider (within an existing clinic/practice).
- Change in Provider or practice name, Tax ID, and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (see section on Provider Panel below for further details).
- Change in specialty.
- Any other information that may impact Member access to care.

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement.

Please visit Molina's Provider Online Directory at MolinaProviderDirectory.com/OH to validate your information. Providers can make updates through the Council for Affordable Quality Healthcare (CAQH) Portal, or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice. Providers unable to make updates through the (CAQH) Portal, or roster process, should contact their Provider Services representative for assistance.

Note: Some changes may impact credentialing. Providers are required to notify Molina of changes to credentialing information in accordance with the requirements outlined in the Credentialing and Recredentialing section of this Provider Appendix.

Molina is required to audit and validate Molina Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network Providers through various methods, such as: letters, phone campaigns, emails, face-to-face contact, fax, and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts the Provider Directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, the Centers for Medicare & Medicaid Services (CMS) recommends that Providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPPES) data.
NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, health plan access to electronic medical records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of the SKYGEN Dental Hub.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the SKYGEN Dental Hub.

Any Provider entering Molina's network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the SKYGEN Dental Hub within 30 days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on Molina's website at MolinaHealthcare.com.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options.
- Electronic Payment: EFT with ERA.
- SKYGEN Dental Hub.

Electronic Claims Submission Requirement

Molina strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance.
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.).
- Increasing accuracy of data and efficient information delivery.
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminating mailing time, which enables Claims to reach Molina faster.

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the SKYGEN Dental Hub.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID SKYGN, refer to the SKYGEN Dental Hub for additional information or see the Claims and Compensation section of this Provider Appendix.

Electronic Payment Requirement

Participating Providers are strongly encouraged to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Molina requires Providers to utilize electronic solutions and tools whenever possible, which include, but are not limited to, health plan access to electronic medical records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims appeal and registration for and use of the SKYGEN Dental Hub.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the SKYGEN Dental Hub. To receive EFT, please complete and return this form: EFT FORM. The form is also available on the SKYGEN Dental Hub and on Molina's website at MolinaHealthcare.com.

Any Provider entering the network as a Contracted Provider will be encouraged to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the SKYGEN Dental Hub within 30 days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at MolinaHealthcare.com.

SKYGEN Dental Hub

Providers and third-party billers can use the no cost SKYGEN Dental Hub to perform many functions online without the need to call or fax Molina. Registration can be performed online and once completed the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps).
- Claims:
  - Submit Claims with attached files.
  - Correct/Void Claims.
  - Add attachments to open or pending submitted Claims.
  - Check Claims status.
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - Create and submit a Claim Appeal with attached files.
- Access an external link to download applicable documents.
- Send/receive secure messages to/from Molina.

Balance Billing

Pursuant to law, Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the state or another payor is responsible for paying such amounts.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as Member Handbooks).

For additional information please refer to the Member Rights and Responsibilities section of this Provider Appendix.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all state and federal laws and regulations and approved by Molina prior to use.

Please contact your Provider Services representative for information and review of any proposed materials you would like to use with Molina Members.

Member Eligibility Verification

Possession of a Molina ID Card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- SKYGEN Dental Hub at SKYGEN Dental Hub
- Molina Provider Services automated IVR system at (800) 642-4168

For additional information please refer to the Enrollment in Medicare Advantage Plans section of this Provider Appendix.

Member Cost Share

Providers must verify the Molina Member's Cost Share status prior to requiring the Member to pay any co-pay, co-insurance, deductible or other Cost Share that may be applicable to the Member's specific benefit plan. Some plans have a total maximum Cost Share that frees the Member from any further out-of-pocket charges once reached (during that calendar year).

Treatment Alternatives and Communication with Members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Compliance

Providers must comply with all state and federal laws and regulations related to the care and management of Molina Members.

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member protected health information (PHI).

For additional information please refer to the Compliance section of this Provider Appendix.

Participation in Grievances and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information please refer to the Medicare Member Grievances and Appeals section of this Provider Appendix.

Provider Panel

If a General Dentist chooses to close their panel to new Members, the Provider must provide 30 days advance notice to Molina. Written correspondence is required and must include the reason and the effective date of the closure. If the panel will not be closed indefinitely, correspondence should also include the re-opening date.

If a re-open date for the panel is not known, the Provider will need to notify Molina when the office is ready to re-open the panel to new patients.

Providers may only close their panels to new Molina Members when their panel is being closed to all new patients, regardless of insurer. Providers must not close their panels to Molina Members only.

Disclosure Requirements

Providers are required to complete the Ownership and Control Disclosure Form during the contracting process and re-attest every 36 months or at any time disclosure must occur to ensure the information is correct and current.

Providers are required to disclose any change in Ownership and Control information in accordance with:

- 42 CFR 455.104 Disclosure by Medicaid Providers and Fiscal Agents: Information on Ownership and Control.

- 42 CFR 455.105 Disclosure by Providers: Information Related to Business Transactions.
- Ohio Revised Code (OAC) 5160-1-17.3 Provider Disclosure Requirements
- 42 CFR 438.230 Subcontractual Relationships and Delegation.

Providers who are contracted through a group affiliation will need to fill out the form at the group level. If a provider is contracted as an individual or independent provider, the form should be filled out at the individual provider level.

The forms are available on our Provider website at MolinaHealthcare.com/OhioProviders under the "Forms" tab in "Provider Forms" under "Contracted Practices/Groups Making Changes."

CREDENTIALING AND RECREDENTIALING

The purpose of the Credentialing Program is to ensure that Molina and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Molina Provider Services Representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing Program has been developed in accordance with state and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-Discriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g., Medicaid) in which the Practitioner specializes. This does not preclude Molina from including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Application

Section 3963.05 of the Ohio Revised Code, standard provider credentialing application form requires all credentialing and recredentialing of physicians and non-physician individual Providers shall be performed using the credentialing form available from CAQH in electronic or paper format. The CAQH credentialing form shall be referred to as the Department of Insurance Part A Credentialing Form. No contracting entity shall require a Provider to provide any information in addition to the information required by the applicable standard credentialing form.

The electronically generated attestation/reattestation form is the equivalent of a signed and dated attestation.

Initial Credentialing Time Frame

Section 3963.06 of the Ohio Revised Code, Notice of Incomplete form – inconsistencies - credentialing requires credentialing to be completed within 90 days of receipt of a complete application and National Practitioner Identifier (NPI).

If a Provider submits a credentialing form that is not complete, the contracting entity that receives the form shall notify the Provider of the deficiency electronically, by facsimile, or by certified mail, return receipt requested no later than 21 days after the contracting entity receives the form.

Communications to Providers

Section 3963.06 of the Ohio Revised Code requires that any communication between the Provider and the contracting entity should be electronic, by facsimile, or by certified mail, return receipt requested.

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Molina network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. Molina may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete, and it will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** –Practitioners must submit to Molina a complete credentialing application either from CAQH ProView or other state mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, Certification or Registration** –Practitioners must hold a current and valid license, certification, or registration to practice in their specialty in every state in which they will provide care and/or render services for Molina Members. Telemedicine practitioners are required to be licensed in the state where they are located and the state where the Member is located.
- **DEA or CDS Certificate** –Practitioners must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Practitioners must have a DEA or CDS in every state where the Practitioner provides care to Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.
- **Specialty** –Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education** –Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required.
- **General Practitioners** – Practitioners who are not board certified and have not completed training from an accredited program are only eligible to be considered for participation as a general Practitioner in the Molina network. To be eligible, the Practitioner must have maintained primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.
- **Work History** –Practitioners must supply most recent five years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the Practitioner must clarify the gap verbally or in writing. The organization will document verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one year, the Practitioner must clarify the gap in writing.
- **Malpractice History** –Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability Claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioners must disclose a full history of all license/certification/registration actions

including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[1]. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.

- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioners must not be currently sanctioned, excluded, expelled, or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security Number. That Social Security Number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner's activities on Molina's behalf. Practitioners maintaining coverage under federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform** – Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable

[1] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any of the following:
  - Criminal convictions, including any convictions, guilty pleas or adjudicated pretrial diversions for crimes against person such as murder, rape, assault, and other similar crimes.
  - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
  - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
  - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
  - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.

    At the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare & Medicaid Services (CMS).

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

Molina will notify the Practitioner immediately if credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice Claims history, board certification actions, sanctions, or exclusions. Molina is not required to reveal the source of information if the

information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

Practitioners have the right to correct erroneous information in their credentials files. Practitioner's rights are published on the Molina website and are included in this Provider Appendix.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information, and may provide any proof that is available.
- The Practitioner's response must be sent to Molina Healthcare, Inc., Attention: Credentialing Director, at PO Box 2470, Spokane, WA 99210.

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing Department will notify the Practitioner.

If the Practitioner does not respond within 10 calendar days, the application processing will be discontinued, and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support the Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina website and are included in this Provider Appendix.

The Practitioner must notify the Credentialing Department and request an appointment time to review their file and allow up to seven calendar days to coordinate schedules. The Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the Practitioner are documents which the Practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have the right, upon request, to be informed of the status of their application by telephone, email, or mail. Practitioner's rights are published on the Molina website and are included in this Provider Appendix. Molina will respond to the request within two working days. Molina will share with the Practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals are not required.

Recredentialing

Molina recredentials every Practitioner at least every 36 months.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

Molina monitors the following agencies for Practitioner sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when occurrences of poor quality are identified. If a Molina Practitioner is found to be sanctioned or excluded, the Practitioner's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** –Monitor for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database** – Molina enrolls all credentialed Practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Practitioners sanctioned by SAM.

Molina also monitors the following for all Practitioner types between the recredentialing cycles.

- Member Complaints/Grievances.
- Adverse Events.
- Medicare Opt-Out.
- Social Security Administration Death Master File.

Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to laws or regulations.

HEALTH CARE SERVICES

Open Communication About Treatment

Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Molina and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans, or other coverage arrangements.

Out-of-Network Providers and Services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process. Molina requires Members to receive non-emergency medical care within the participating, contracted network of Providers. Services provided by non-contracted Providers must be prior authorized. Exceptions include Emergency Services and Medically Necessary dialysis services obtained by the Member when they are outside the service area. See the section on Emergency Services, Urgent Care, and Post-Stabilization Services above. When no exception applies, Molina will determine whether there are contracted Providers within the service area willing and able to provide the items or services requested for the Member.

Continuity of Care and Transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide Covered Services to the Member up to 90 days or longer, if necessary, for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- High risk for second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer, if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Molina at (800) 642-4168.

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is or receiving or may be in need of receiving community care services by reason of mental or other disability, age, or illness; and who is or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect, and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses.
- Public or private school employees or childcare givers.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

Suspected abuse and/or neglect should be reported as follows:

Child Abuse

The Ohio Department of Job and Family Services has launched 855-O-H-Child (855-642-4453), an automated telephone directory that will link callers directly to a child welfare or law enforcement office in their county.

Adult Abuse

Adult protective services for adults aged 60 and older can be reached at the Ohio Department of Job and Family Services at 855-OHIO-APS (855-644-6277).

Molina's HCS teams will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities, or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina will follow up with Members that are reported to have been abused, exploited, or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper state agency.

QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality Department toll free at (855) 322-4079.

The address for mail requests is:

Molina Medicare of Ohio
Quality Improvement Department
PO Box 349020
Columbus, OH 43234-9020

This Provider Appendix contains excerpts from the Molina Quality Improvement Program. For a complete copy of Molina's Quality Improvement Program, you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

Molina has established a Quality Improvement Program that complies with regulatory requirements and accreditation standards. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service, and health of Molina Members. In our Quality Program description, we describe our program governance, scope, goals, measurable objectives, structure, and responsibilities.

Molina does not delegate Quality Improvement activities to Dental Providers/Dental Provider Groups. However, Molina requires contracted Dental Providers/Dental Provider Groups to comply with the following core elements and standards of care. Dental Providers/Dental Provider Groups must:

- Have a Quality Improvement Program in place.
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations.
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services and Member experience.
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability.
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe personal health practices for Molina Members through our Safety Program, Pharmaceutical Management and Care Management/Disease Management Programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital-acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to Congress regarding the incidence of “never events” among Medicare beneficiaries, the payment for services in connection with such events, and the Centers for Medicare & Medicaid Services (CMS) processes to identify events and deny payment.

DENTAL RECORDS

Molina requires that dental records be maintained in a manner that is current, detailed, and organized to ensure that care rendered to Members is consistently documented (hard copy or electronic) and that necessary information is readily available in the dental record in accordance with Molina Healthcare of Nebraska’s policies and procedures. All entries will be indelibly added to the Member’s record. A Member's dental record is the property of the provider who generates the record. PCDs should maintain the following dental record components that include but are not limited to:

Medical record confidentiality and release of dental records within medical and behavioral health care records.

Each Member is entitled to a copy of their dental record at no cost.

Upon notification of a Member transferring providers, Molina will ensure their dental records or copies of dental records are forwarded to the new PCD within ten (10) business days from receipt of the request for transfer of the dental records.

MLTC is not required to obtain written approval from a Member before requesting the Member's dental record from the PCD or any other organization or agency.

Molina Healthcare of Nebraska must afford MLTC access to all Members' dental records, whether electronic or paper, in the form, manner, and deadline directed by MLTC.

Medical record content and documentation standards include legibility, accuracy, and plan of care that comply with applicable law and Molina written standards.

Storage maintenance and disposal processes.

Process for archiving dental records and implementing improvement activities.

If care has not been established, information may be kept temporarily in an appropriately labeled file, in lieu of a permanent dental record.

The temporary file must be associated with the Member’s dental record as soon as one is established.

Information related to fraud and abuse may be released. However, HIV-related information may not be disclosed except as provided in state statute, and substance use disorder

information shall only be disclosed consistent with Federal and State law including, but not limited to 42 CFR § 2.1 et seq.

Dental Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the Member's Dental records:

- Each patient has a separate record.
- All records are to be in a locked secure environment
- Records are available at each visit and archived records are available within 24 hours.
- If hard copy, pages are securely attached in the dental record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and HIPAA compliance.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving dental records and implementing improvement activities.
- Records are kept confidential and there is a process for release of dental records.

Dental Record Content

Providers must remain consistent in their practices with Molina's dental record documentation guidelines. Medical records are maintained and should include the following information:

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, gender, legal guardianship (if applicable), marital status, address, employer, home and work telephone numbers, and emergency contact.
- Primary language spoken by the Member and any translation needs.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- The primary care dentist is responsible for documenting all services provided directly by the PCD. This includes all ancillary and diagnostic services ordered by the PCD, and all diagnostic and therapeutic services for which the member was referred by the PCD. At a minimum, each dental record must contain the following:
- Member demographics: Member name, member ID number, date of birth, gender, marital status, address, employer, home and work telephone numbers, emergency contact information, primary language, and translation needs;
- Legible signature and credentials of provider and other staff members if a paper dental record; after each entry into progress notes. Process notes should include:
- Review of medical history;
- Exam findings and diagnosis

- Verbal or written informed consent;
- Date of Service
- Services performed including:
  - tooth number;
  - arch;
  - Surfaces;
  - Quadrant;
- Summary of the appointment and discussions with the member
- Review treatment for the next visit as applicable
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions (or notation that none are known);
- Treatment plans are consistent with diagnosis;
- A working diagnosis is recorded with the clinical findings;
- Progress notes clearly and thoroughly state the intent for all ordered services and treatments;
- There are notations regarding follow-up care, calls, or visits, including the next preventative care visit when appropriate;
- Notes from consultants are in the record if applicable;
- All staff and provider notes are signed physically or electronically with either name or initials;
- All entries are dated;

Dental Record Organization

- The dental record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each Member authorizing Molina to release dental information for facilitation of dental care.

Dental Record Retrieval

- The dental record is available to Provider at each encounter.
- The dental record is available to Molina for purposes of Quality Improvement.
- The dental record is available to the applicable State and/or Federal agency and the External Quality Review Organization upon request.
- The dental record is available to the Member upon their request at no cost.
- A storage system for inactive Member dental records which allows retrieval within 24 hours, is consistent with State and Federal requirements, and the record is maintained for

not less than 10 years from the last date of treatment or for a minor, one year past their 20th birthday but, never less than 10 years.

- An established and functional data recovery procedure in the event of data loss.

Access to Care

Molina maintains Access to Care Standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include OB/GYN (high-volume specialists), Oncologist (high-impact specialists), and behavioral health Providers. Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 90 percent availability for Emergency Services and 90 percent or greater for all other services. The PCP or their designee must be available 24 hours a day, seven days a week to Members.

Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted:

Dental Appointment

Type of Visit	Description	Minimum Standard
Emergency Dental Service	Services that are needed to evaluate, treat, or stabilize an emergency dental condition.	24 hours, 7 days/week
Urgent Dental Care	Care that is provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headache. Acute illness or substance dependence impacts the ability to function but does not present an imminent danger.	24 hours, 7 days/week within 48 hours of request
Dental Appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 30 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, seven days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang up and call 911 or go immediately to the nearest emergency room. After hours voicemail without these instructions is not acceptable.

Monitoring Access for Compliance with Standards

Access to Care Standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis.

Provider Network adherence to access standards is monitored via one or more of the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios, and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practice standards. Molina continually monitors Member appeals and complaints /grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical Accessibility.
- Physical Appearance.
- Adequacy of Waiting and Examining Room Space.

Physical Accessibility

Molina evaluates office sites as applicable, to ensure that Members have safe and appropriate access to the office site. This access includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

The site visits include but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of Waiting and Examining Room Space

During the site visit as required, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration and Confidentiality of Facilities

Facilities contracted with Molina must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available.
- Yearly Occupational Safety and Health Administration (OSHA) training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, contracts, and evidence hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers, or labels are possible alternative methods.

- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Dental records are stored away from patient areas. Record rooms and/or file cabinets are locked.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for expiration outdates.
- Drug refrigerator temperatures are documented daily.

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Performance below Molina's standards may result in a Correction Action Plan (CAP) with a request that the Provider submit a written corrective action plan to Molina within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program. The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Cultural and Linguistic Services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's program and services, please see the Cultural Competency and Linguistic Services section of this Provider Appendix.

Measurement of Clinical and Service Quality

Molina monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

- Health Outcomes Survey (HOS)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

Molina evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Molina's most recent results can be obtained from your local Molina Quality department or by visiting Molina's website at MolinaHealthcare.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, obstetric and gynecological health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are the measurement standard for many of Molina's clinical quality activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of Molina's contracts with these agencies. The data results are also used to compare to established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS® is the tool used by Molina to summarize Member Satisfaction with the Providers, health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care and Getting Needed Prescription Drugs. The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA-Certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

Molina monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Molina also compiles complaint and appeals data as well as requests for out-of-network services to determine opportunities for service improvements.

Medicare Star Ratings – The Affordable Care Act

Star Ratings are a system of measurements CMS uses to determine how well physicians and health plans are providing care to Medicare Members. This system is based on nationally recognized quality goals such as "The Triple Aim" and the Institute of Medicine's "Six Aims," which focus on improving the health and care of your patients, safe and effective care, as well as making care affordable.

What Can Providers Do?

- Ensure patients are up to date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology.
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed.
- Check that staff is properly coding all services provided.

- Be sure patients understand what they need to do.

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the SKYGEN Dental Hub. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Molina Quality Department.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

COMPLIANCE

Fraud, Waste, and Abuse

Molina is dedicated to the detection, prevention, investigation and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance Department maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. Molina also addresses fraud, waste, and abuse prevention, detection, and correction along with the education of appropriate employees, vendors, Providers, and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to prevent, detect, , and correct fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission Statement

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care costs and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent Claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the Claim.

- Acts in deliberate ignorance of the truth or falsity of the information in a Claim.
- Acts in reckless disregard of the truth or falsity of the information in a Claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent Claims to the government, such as knowingly making false statements, falsifying records, double billing for items or services, submitting bills for services never performed or items never furnished, or otherwise causing a false Claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of funds either by fraud, waste, or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The federal False Claims Act and state laws pertaining to submitting false Claims.
- How Providers will detect and prevent fraud, waste, and abuse.
- Employee protection rights as whistleblowers.

These provisions encourage employees (current or former) and others to report instances of fraud, waste, or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against due to their role in disclosing or reporting a false Claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority.
- Two times the amount of backpay plus interest.
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the law.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute ("AKS") is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

Molina conducts all business in compliance with Federal and State Anti-Kickback Statutes (AKS) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKS?

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKS actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under Molina's policies, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of Federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both State and Federal.

Under Molina's policies, Marketing means any communication, to a beneficiary who is not enrolled with Molina, that can reasonably be interpreted as intended to influence the beneficiary to enroll with Molina's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another Health Plan's products.

Restricted marketing activities vary from state-to-state but generally relate to the types and form of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law [42 U.S.C. § 1395nn].

Sarbanes-Oxley Act of 2002

Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable Federal or state law. (42 CFR § 455.2)

Waste: means health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g., coding) causing unnecessary costs to state and federal health care programs.

Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to state and federal health care programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to state and federal health care programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

The types of questionable Provider schemes investigated by Molina include, but are not limited to the following:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)

- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization.
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste and Abuse by a Member

The types of questionable Member schemes investigated by Molina include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud state and federal health care programs.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.

- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from, and the Member sells the medication to someone else.

Review of Provider Claims and Claims System

Molina Claims Examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

The Claims payment system utilizes system edits and flags to validate those elements of Claims are billed in accordance with standardized billing practices, ensure that Claims are processed accurately and ensure that payments reflect the service performed as authorized.

Molina performs auditing to ensure the accuracy of data input into the Claims system. The Claims Department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste and Abuse Detection Activities

Through implementation of Claims edits, Molina's Claims payment system is designed to audit Claims concurrently, in order to detect and prevent paying Claims that are inappropriate.

Molina has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from specific state Medicaid Guidelines, Centers for Medicare & Medicaid Services (CMS), federal CMS guidelines, American Medical Association (AMA) and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and state-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Molina may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Appendix are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts, patient charts, billing records and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to Provider's records, all of the Claims for which Provider received payment from Molina is immediately due and owing. If Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy laws.

Claim Auditing

Molina shall use established industry Claims adjudication and/or clinical practices, state, and federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Molina paid in error. The estimated proportion, or error rate, may be projected across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Provider Education

When Molina identifies through an audit or other means a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, Molina may determine that a Provider education visit is appropriate.

Molina will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan (CAP)to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available 24 hours a day, seven days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report.

Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached toll free at (866) 606-3889 or you may use the service's website to make a report at any time at MolinaHealthcare.alertline.com

You may also report cases of fraud, waste, or abuse to Molina's Compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Medicare of Ohio
Attn: Compliance
200 Oceangate, Suite 100
Long Beach, CA 90802

Remember to include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Molina Member ID number and any other identifying information.

Suspected fraud, waste and abuse may also be reported to CMS:

- CMS Toll Free Phone: 1-800-MEDICARE (1-800-633-4227)
- Phone to the Health and Human Services Office of the Inspector General at (800) 447-8477 or TTY/TDD (800) 377-4950.
- Online via the Health and Human Services Office of the Inspector General website.
- Fax to (800) 223-8164, maximum of 10 pages.
- By Mail to:
  Office of Inspector General
  Attn: OIG Hotline Operations
  PO Box 23489
  Washington, DC 20026

HIPAA (Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all federal and state laws regarding the privacy and security of Members' PHI.

Provider Responsibilities

Molina expects that its contracted Provider will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law, including:

- 42 C.F.R. Part 2 Regulations
- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Applicable Laws

Providers must understand all state and federal health care privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead, there is a patchwork of laws that Providers must comply with. In general, most health care Providers are subject to various laws and regulations pertaining to privacy of health information, including, without limitation, the following:

1. **Federal Laws and Regulations**
    - HIPAA
    - The Health Information Technology for Economic and Clinical Health Act (HITECH)
    - 42 C.F.R. Part 2
    - Medicare and Medicaid Laws
    - The Affordable Care Act

2. **State Medical Privacy Laws and Regulations**

    Providers should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of

the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[2]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[3]."

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

   - Quality Improvement
   - Disease Management
   - Care Management and Care Coordination
   - Training Programs
   - Accreditation, Licensing and Credentialing

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as HEDIS® and Quality Improvement.

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction, and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

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[1] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.

[3] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Patient Rights

Patients are afforded various rights under HIPAA. Molina Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of Privacy Practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for Patient Access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to Amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.

6. **Request Accounting of PHI Disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity measures. Providers should recognize that identity

theft – both financial and medical – is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA Transactions and Code Sets

Molina strongly supports the use of electronic transactions to streamline health care administrative activities. Molina Providers are encouraged to submit Claims and other transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and Encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional."
2. Click the tab titled "HIPAA."
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets."

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or

subparts information must be reported to NPPES within 30 days and should also be reported to Molina within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and Utilization Management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for Copies of PHI

Molina does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment, and/or Operation Purposes
- Collection of HEDIS® medical records

Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure continuation and recovery of services after a Disaster Declaration. The BCP will be updated at least annually and approved by the applicable designated representative.

The Provider Business Continuity Plan will include:

- Names and contact information for staff responsible for invoking and managing response and recovery
- Disaster Declaration process
- Details of how the services will be recovered and restored
- Disaster Recovery Plan which includes details of how the systems and applications supporting the services will be recovered and restored, including recovery of data

The Provider will notify Molina Provider Services of a disruption to the services or activation of business continuity plans within two hours of occurrence and will provide Molina with regular

updates on the situation and actions taken to resolve the issue, until normal services have been resumed.

The Provider will ensure that its third parties needed to deliver the services have appropriate Business Continuity Plans in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Provider will make available to Molina, upon request, the results of the most recent test including lessons learned and remediation plans.

The Provider will participate in Molina annual tests upon notification and mutual agreement.

Definitions

Business Continuity Plan: documented procedures that guide organizations to respond, recover, resume, and restore to a pre-defined level of operations following a disruption.

Disaster Recovery Plan: a document that defines the resources, actions, tasks, and data required to manage the technology recovery effort.

Disaster Declaration: criteria to declare a disaster and the staff authorized to invoke recovery plans to recover and restore Services.

Cybersecurity Requirements

Note: This section (Cybersecurity Requirements) is only applicable to providers who are delegated Providers and have been delegated by Molina to perform a health plan function.

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by law or any enforcement agency.
2. The following terms are defined as follows:
    I. "Consumer" means an individual who is a State resident, whose Nonpublic Information is in Molina's possession, custody or control and which Provider maintains, processes, stores, or otherwise has access to such Nonpublic Information.
    II. "Cybersecurity Event" means any act or attempt, successful or, to the extent known by Provider, unsuccessful, to gain unauthorized access to, disrupt or misuse an Information System or Nonpublic Information stored on such Information System. The ongoing existence and occurrence of attempted but Unsuccessful Security Incidents shall not constitute a Cybersecurity Event under this definition. "Unsuccessful Security Incidents" are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Molina Nonpublic Information or sustained interruption of service obligations to Molina.

III. “Information System” or “Information Systems” means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic Nonpublic Information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

IV. “Nonpublic Information” means information that is not publicly available information and is one of the following:

(a) business related information of Molina the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina;

(b) any information concerning a Consumer that because of the name, number, personal mark, or other identifier contained in the information can be used to identify such Consumer, in combination with any one or more of the following data elements:

(i) social security number;

(ii) driver’s license number, commercial driver’s license, or state identification card number;

(iii) account number, credit, or debit card number;

(iv) security code, access code, or password that would permit access to a Consumer’s financial account; or

(v) biometric records;

(c) any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a Consumer, that can be used to identify a particular Consumer, and that relates to any of the following:

(i) the past, present, or future physical, mental, or behavioral health or condition of a Consumer or a member of the Consumer’s family;

(ii) the provision of health care to a Consumer; or

(iii) payment for the provision of health care to a Consumer.

V. “State” means the State of Ohio.

3. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information, as defined herein, that are accessible to, or held by, the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the State Department of Insurance, as appropriate.

4. Provider agrees to comply with all applicable laws governing Cybersecurity Events. Molina will decide on notification to affected Consumers or government entities, except where Provider is solely responsible and required to notify such Consumers or government entities by Law. Upon Molina’s prior written request, Provider agrees to assume responsibility for informing all such Consumers in accordance with applicable law.

5. In the event of a Cybersecurity Event, Provider shall notify Molina's Chief Information Security Officer of such Cybersecurity Event by telephone and email (as provided below) as promptly as possible, but in no event later than 24 hours from a determination that a Cybersecurity Event has occurred. In addition to the foregoing, Provider shall notify Molina's Chief Information Security Officer (by telephone and email) within 24 hours following payment of a ransom that involves or may involve Molina Nonpublic Information.

   Notification to Molina's Chief Information Security Officer shall be provided to:

   Molina Chief Information Security Officer
   Telephone: (844) 821-1942
   Email: CyberIncidentReporting@molinahealthcare.com

   A follow-up notification shall be provided by mail, at the address indicated below.

   Molina Chief Information Security Officer
   Molina Healthcare, Inc.
   200 Oceangate Blvd., Suite 100
   Long Beach, CA 90802
6. Upon Provider's notification to Molina of a determination of a Cybersecurity Event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation, or, upon written request by Molina, Provider shall complete an investigation pursuant to the following requirements:
   (a) determine whether a Cybersecurity Event occurred;
   (b) assess the nature and scope of the Cybersecurity Event;
   (c) identify Nonpublic Information that may have been involved in the Cybersecurity Event; and
   (d) perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of the Nonpublic Information.
7. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon request of Molina.
8. Provider must provide to Molina the following information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina in the initial and subsequent notices must include as much of following information known to Provider at the time of the notification:
   (a) the date of the Cybersecurity Event;
   (b) a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of Provider, if any;
   (c) how the Cybersecurity Event was discovered;

(d) whether any lost, stolen, or breached information has been recovered and if so, how this was done;
(e) the identity of the source of the Cybersecurity Event;
(f) whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
(g) a description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the Consumer;
(h) the period during which the Information System was compromised by the Cybersecurity Event;
(i) the number of total Consumers in the State affected by the Cybersecurity Event;
(j) the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
(k) a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
(l) a copy of Provider's privacy policy and if requested by Molina, the steps that Provider will take to notify Consumers affected by the Cybersecurity Event; and
(m) the name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

9. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments.

In the event provisions of this Section conflict with provisions of any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization

will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com, from your local Provider Services representative and by calling Molina Provider Services Team at (855) 322-4079.

Nondiscrimination in Health Care Service Delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); State law; and Federal program rules, including Section 1557 of the ACA.
You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation of the need for frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found on the Member pages of Molina's website at https://www.molinahealthcare.com/members/oh/en-us/mem/medicare/medicare.aspx.
3. You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found on the Member pages of Molina's website at https://www.molinahealthcare.com/members/oh/en-us/mem/medicare/medicare.aspx.
4. If a Molina Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). You can find resources on meeting your LEP obligations at https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html. See also, https://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.
5. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

TTY/TDD, 711 civil.rights@MolinaHealthcare.com	Website: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Form: https://www.hhs.gov/ocr/complaints/index.html

If you or a Molina Member needs additional help or more information, call (800) 368-1019 or TTY/TDD (800) 537-7697.

Cultural Competency

Molina is committed to reducing health care disparities and partnering with Providers to collectively advance health equity. Training employees, Providers and their staff is essential to build a foundation towards increased cultural humility and more equitable outcomes. Additionally, Member input, collaboration, as well as quality monitoring, are the cornerstones of successful culturally humble service delivery. With intentional effort to stratify health care services and health outcomes by demographic attributes such as race, ethnicity, gender, sexual orientation, and gender identity, Molina leverages disparity reduction initiatives to advance equitable outcomes for populations groups that have been historically marginalized. Molina integrates Cultural Competency/Cultural Humility training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about Molina Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations (CBO). Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services and/or online/web-based training modules.

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials.
2. Online cultural competency Provider training modules.
3. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

Integrated Quality Improvement – Ensuring Access

Molina ensures Member access to language services such as oral interpretation, American Sign Language (ASL), and written translation. Molina must also ensure access to programs, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with LEP.

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e., Braille, audio, large print), leading to better communication, understanding and Member satisfaction. Online materials found on MolinaHealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key Member information, including Appeal and Grievance forms, are also available in threshold languages on the Molina Member website.

Access to Interpreter Services

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

All eligible members who are Limited English Proficient (LEP) are entitled to receive interpreter services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP) or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist Providers with locating these services if needed.

An LEP individual has a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations).

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Be given access to Care Managers trained to work with individuals with cognitive impairments.
- Be notified by the medical Provider that interpreter services are available at no cost.
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
  - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.
  - Interpreters may, with Member written consent, share information from the Member’s records only with appropriate medical professionals and agencies working on the Member’s behalf.

- Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

Interpreters include people who can speak the Member's native language, assist with a disability, or help the Member understand the information.

When Molina Members need an interpreter, limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing and/or limited reading services are available.
- Molina is available to assist Providers with locating these services if needed:
  - Providers needing assistance finding onsite interpreter services may call Molina Member Services.
  - Providers needing assistance finding translation services may call Molina Member Services.
  - Providers with Members who cannot hear or have limited hearing ability may use the Ohio Relay service (TTY/TDD) at 711.
  - Providers with Members with limited vision may contact Molina Member Services for documents in large print, Braille, or audio version.
  - Providers with Members with limited reading proficiency (LRP) may contact Molina Member Services.
- The Molina Member Service Representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Contact Molina Member Services at:

- Medicare: (866) 472-4584 (TTY/TDD/Ohio Relay 711), Monday through Saturday from 8 a.m. to 8 p.m.

Molina asks Providers to inform Molina when providing interpreter services to Molina Members. Providers may report this information to Molina by calling Molina Member Services.

Documentation

As a contracted Molina Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by Molina.
- Document all Member requests for interpreter services.

- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend, or minor as an interpreter, or refuses the use of interpreter services after notification of their right to have a qualified interpreter at no cost.

Members Who Are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member and Provider Contact Center, Quality, Health Care Services, and all other health plan functions.

Molina strongly recommends that Provider offices make available assistive listening devices for Members who are deaf and hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

Molina will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made three business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via Molina Member Services.

Program and Policy Review Guidelines

Molina conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity, and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Evidence of Coverage (EOC). The EOC that is provided to Members annually is hereby incorporated into this Provider Appendix. The most current EOC can be found on the Member pages of Molina's website. Link: molinahealthcare.com/members/oh/en-us/mem/medicare/plan-materials.aspx. Refer to Chapter 8 which is titled "Your Rights and Responsibilities".

State and federal law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact Molina at (800) 642-4168, Monday to Saturday, 8 a.m. to 8 p.m., local time. TTY/TDD users, please call 711.

Second Opinions

If a Member does not agree with the Provider's plan of care, the Member has the right to request, at no cost, a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require prior authorization.

ELIGIBILITY AND ENROLLMENT IN MEDICARE ADVANTAGE PLANS

Enrollment Information

Members who wish to enroll in Molina Medicare Advantage Plans must meet the eligibility criteria as outlined in the Molina Evidence of Coverage (EOC). The most current EOC can be found on the Member pages of Molina's website. Link: molinahealthcare.com/members/oh/en-us/mem/medicare/plan-materials.aspx.

Refer to Chapter 1 which is titled "Getting started as a Member."

Furthermore, Molina does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in Chapter 2 of the Medicare Managed Care Manual.

Members Toll-Free Telephone Numbers

Members may call our Member Contact Center toll free at (866) 472-4584, Monday to Saturday, from 8 a.m. to 8 p.m., local time, or TTY/TDD 711, for persons with hearing impairments.

Effective Date of Coverage

Molina will determine the effective date of enrollment for all enrollment requests. The effective date of coverage is determined when the complete enrollment is signed and received, following the Member's enrollment election period.

Disenrollment

Staff of Molina may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare Member to disenroll; except as outlined in the Molina Evidence of Coverage (EOC). The most current EOC can be found on the Member pages of Molina's website. Link: molinahealthcare.com/members/oh/en-us/mem/medicare/plan-materials.aspx.

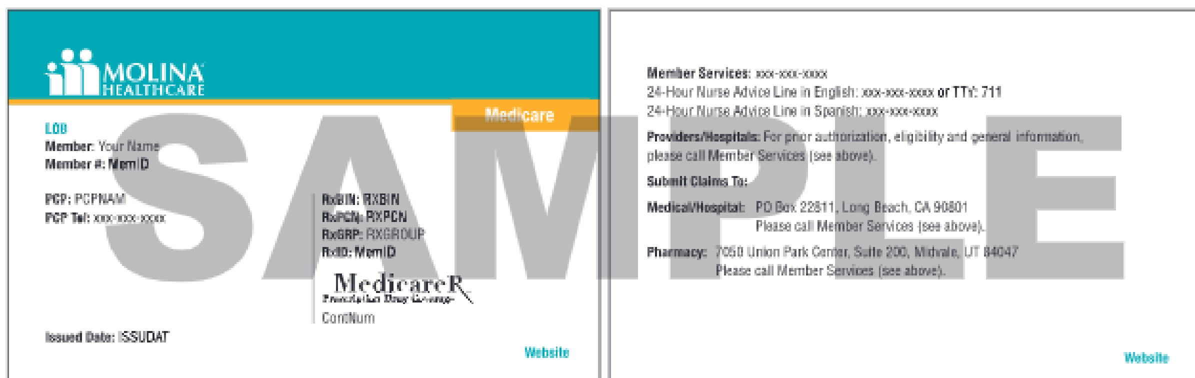
Refer to Chapter 10 which is titled "Ending your membership in the plan"

In all circumstances except death, Molina will provide a written notice to the Member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS.

In the event of death, a verification of disenrollment will be sent to the deceased Member's estate.

Member Identification Card Example – Medical Services

The Member Identification Card presented by a Molina Member may look different than the sample card below. It is the Provider's responsibility to ensure Molina Members are eligible for benefits prior to rendering services.



Verifying Eligibility

To ensure payment, Providers must verify eligibility at every visit. Possession of the ID card does not guarantee Member eligibility or coverage. It is the responsibility of the Provider to verify the eligibility of the cardholder.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- SKYGEN Dental Hub at [SKYGEN Dental Hub]()

- Molina Provider Services automated IVR system at (855) 322-4079

BENEFIT OVERVIEW

Molina Medicare Advantage Benefits

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D0120	PERIODIC ORAL EXAM	0-999		
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	0-999		
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	0-999		ONE PER LIFETIME
D0180	COMPREHENSIVE PERIODONTAL EVALUATION	0-999		ONE PER LIFETIME
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	0-999		
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL IMAGE	0-999		
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	0-999		
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	0-999		
D0330	PANORAMIC RADIOGRAPHIC IMAGE	0-999		
D0372	INTRAORAL TOMOSYNTHESIS – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES	0-999		
D0373	INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE	0-999		
D0374	INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE	0-999		ONE PER ACCUM YEAR

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D0999	FQHC ENCOUNTER PAYMENT	0-999		
D1110	PROPHYLAXIS - ADULT	0-999		TWO PER ACCUM YEAR
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	0-999		
D1208	TOPICAL APPLICATION OF FLUORIDE	0-999		
D2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT	0-999	ALL TEETH (TEETH 1 - 32, A - T)	
D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT	0-999	ALL TEETH (TEETH 1 - 32, A - T)	
D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT	0-999	ALL TEETH (TEETH 1 - 32, A - T)	
D2161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	0-999	ALL TEETH (TEETH 1 - 32, A - T)	
D2330	RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR	0-999	ANTERIOR TEETH (TEETH 6 - 11, 22 - 27, C - H, M - R)	
D2331	RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR	0-999	ANTERIOR TEETH (TEETH 6 - 11, 22 - 27, C - H, M - R)	

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	0-999	ANTERIOR TEETH (TEETH 6 - 11, 22 - 27, C - H, M - R)	
D2335	RESIN-BASED COMPOSITE – FOUR OR MORE SURFACES (ANTERIOR)	0-999	ANTERIOR TEETH (TEETH 6 - 11, 22 - 27, C - H, M - R)	
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR	0-999	POSTERIOR TEETH (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	0-999	POSTERIOR TEETH (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	0-999	POSTERIOR TEETH (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	0-999	POSTERIOR TEETH (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	
D2510	INLAY - METALLIC - ONE SURFACE	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2520	INLAY - METALLIC - TWO SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D2530	INLAY - METALLIC - THREE SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2542	ONLAY - METALLIC - TWO SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2543	ONLAY - METALLIC - THREE SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2544	ONLAY - METALLIC - FOUR OR MORE SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2620	INLAY - PORCELAIN/CERAMIC - TWO SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2630	INLAY - PORCELAIN/CERAMIC - THREE SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2642	ONLAY - PORCELAIN/CERAMIC - TWO SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2643	ONLAY - PORCELAIN/CERAMIC - THREE SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D2644	ONLAY - PORCELAIN/CERAMIC - FOUR OR MORE SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2650	INLAY - RESIN-BASED COMPOSITE - ONE SURFACE	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2651	INLAY - RESIN-BASED COMPOSITE - TWO SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2652	INLAY - RESIN-BASED COMPOSITE - THREE SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2662	ONLAY - RESIN-BASED COMPOSITE - TWO SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2663	ONLAY - RESIN-BASED COMPOSITE - THREE SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2664	ONLAY - RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2710	CROWN - RESIN-BASED COMPOSITE (INDIRECT)	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D2712	CROWN - 3/4 RESIN-BASED COMPOSITE (INDIRECT)	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2720	CROWN - RESIN WITH HIGH NOBLE METAL	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2722	CROWN - RESIN WITH NOBLE METAL	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2740	CROWN - PORCELAIN/CERAMIC	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2781	CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D2782	CROWN - 3/4 CAST NOBLE METAL	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2783	CROWN - 3/4 PORCELAIN/CERAMIC	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2790	CROWN - FULL CAST HIGH NOBLE METAL	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2792	CROWN - FULL CAST NOBLE METAL	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2794	CROWN – TITANIUM AND TITANIUM ALLOYS	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2799	PROVISIONAL CROWN	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2951	PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	0-999	ALL TEETH (TEETH 1 - 32, A - T)	
D2953	EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	0-999	ALL TEETH (TEETH 1 - 32, A - T)	
D2980	CROWN REPAIR	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D3220	THERAPEUTIC PULPOTOMY	0-999	ALL TEETH (TEETH 1 - 32, A - T)	
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	0-999	PERMANENT ANTERIOR (TEETH 6 - 11, 22 - 27)	
D3320	ENDODONTIC THERAPY, PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION)	0-999	BICUSPIDS (TEETH 4, 5, 12, 13, 20, 21, 28, 29)	
D3330	ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)	0-999	PERMANENT MOLARS (TEETH 1 - 3, 14 - 19, 30 - 32)	
D3410	APICOECTOMY - ANTERIOR	0-999	PERMANENT ANTERIOR (TEETH 6 - 11, 22 - 27)	

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D3421	APICOECTOMY - PREMOLAR (FIRST ROOT)	0-999	BICUSPIDS (TEETH 4, 5, 12, 13, 20, 21, 28, 29)	
D3425	APICOECTOMY - MOLAR (FIRST ROOT)	0-999	PERMANENT MOLARS (TEETH 1 - 3, 14 - 19, 30 - 32)	
D3426	APICOECTOMY - EACH ADDITIONAL ROOT)	0-999	PERMANENT POSTERIOR (TEETH 1 - 5, 12 - 21, 28 - 32)	
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	0-999	QUADRANTS (LL, LR, UR, UL)	
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT	0-999	QUADRANTS (LL, LR, UR, UL)	
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSTIC	0-999		ONE PER ACCUM YEAR
D4910	PERIODONTAL MAINTENANCE	0-999		TWO PER ACCUM YEAR
D5110	COMPLETE DENTURE - MAXILLARY	0-999		
D5120	COMPLETE DENTURE - MANDIBULAR	0-999		
D5130	IMMEDIATE DENTURE - MAXILLARY	0-999		
D5140	IMMEDIATE DENTURE - MANDIBULAR	0-999		
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	0-999		

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	0-999		
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	0-999		
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	0-999		
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE	0-999		
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE	0-999		
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN BASE	0-999		
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN BASE	0-999		
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY RETENTIVE CLASPING MATE	0-999		
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY RETENTIVE CLASPING MAT	0-999		
D5227	IMMEDIATE MAXILLARY PARTIAL DENTURE – FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS	0-999		

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D5228	IMMEDIATE MANDIBULAR PARTIAL DENTURE – FLEXIBLE BASE (INCLUDING ANY CLASPS, REST	0-999		
D5511	REPAIR BROKEN COMPLETE DENTURE BASE - MANDIBULAR	0-999		
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	0-999		
D5520	REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE (EACH TOOTH) – PER TOOTH	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D5611	REPAIR RESIN DENTURE BASE - MANDIBULAR	0-999		
D5612	REPAIR RESIN DENTURE BASE - MAXILLARY	0-999		
D5621	REPAIR CAST FRAMEWORK - MANDIBULAR	0-999		
D5622	REPAIR CAST FRAMEWORK - MAXILLARY	0-999		
D5630	REPAIR OR REPLACE BROKEN CLASP - PER TOOTH	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D5640	REPLACE MISSING OR BROKEN TEETH – PARTIAL DENTURE – PER TOOTH	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE – PER TOOTH	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE - PER TOOTH	0-999	ALL PERMANENT TEETH (TEETH 1 - 32)	
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	0-999		
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	0-999		
D5710	REBASE COMPLETE MAXILLARY DENTURE	0-999		
D5711	REBASE COMPLETE MANDIBULAR DENTURE	0-999		
D5720	REBASE MAXILLARY PARTIAL DENTURE	0-999		
D5721	REBASE MANDIBULAR PARTIAL DENTURE	0-999		
D5725	REBASE HYBRID PROSTHESIS	0-999	ARCHES (UA, LA)	
D5730	RELINE COMPLETE MAXILLARY DENTURE (DIRECT)	0-999		
D5731	RELINE COMPLETE MANDIBULAR DENTURE (DIRECT)	0-999		
D5740	RELINE MAXILLARY PARTIAL DENTURE (DIRECT)	0-999		
D5741	RELINE MANDIBULAR PARTIAL DENTURE (DIRECT)	0-999		
D5750	RELINE COMPLETE MAXILLARY DENTURE (INDIRECT)	0-999		
D5751	RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT)	0-999		

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D5760	RELINE MAXILLARY PARTIAL DENTURE (INDIRECT)	0-999		
D5761	RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT)	0-999		
D5765	SOFT LINER FOR COMPLETE OR PARTIAL REMOVABLE DENTURE – INDIRECT	0-999	ARCHES (UA, LA)	
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT	0-999	ALL TEETH (TEETH 1-32, A-T, 51-82, AS-TS)	
D7210	EXTRACTION, ERUPTED TOOTH	0-999	ALL TEETH (TEETH 1-32, A-T, 51-82, AS-TS)	
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	0-999	ALL TEETH (TEETH 1-32, A-T, 51-82, AS-TS)	
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	0-999	ALL TEETH (TEETH 1-32, A-T, 51-82, AS-TS)	
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	0-999	ALL TEETH (TEETH 1-32, A-T, 51-82, AS-TS)	
D7241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, UNUSUAL SURGICAL COMPLICATIONS	0-999	ALL TEETH (TEETH 1-32, A-T, 51-82, AS-TS)	
D7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE	0-999		

CODE	DESCRIPTION	AGE	COVERED AREA	BENEFIT LIMITATION
D7511	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED	0-999		
D7520	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE	0-999		
D7521	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE - COMPLICATED	0-999		
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN - PER VISIT	0-999		FOUR PER ACCUM YEAR
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	0-999		
D9223	DEEP SEDATION / GENERAL ANESTHESIA - EACH SUBSEQUENT 15 MINUTE INCREMENT	0-999		
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES	0-999		
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - EACH SUBSEQUENT 15 MINUTE	0-999		FOUR PER ACCUM YEAR

If there are questions as to whether a service is covered, please reference the tools located at on the Molina website and the SKYGEN Dental Hub. You may also contact Molina's Provider Contact Center toll free at (855) 322-4079, seven days a week, from 8 a.m. to 8 p.m., local time, or TTY/TDD 711, for persons with hearing impairments.

Provider Education on Covered Benefits and Member Access to Care

Providers are educated on the tools and information required to ensure Members understand their benefits and how to access care. This includes but is not limited to:

- How to identify Medicare and Medicaid covered benefits by accessing the appropriate plan or state agency materials (see hyperlinks below).

Medicaid-Covered Benefits

Medicaid covered services not covered by Molina SNP can be found in Ohio's Medicaid website at medicaid.ohio.gov/FOR-OHIOANS/Covered-Services.

CLAIMS AND COMPENSATION

Payer ID	**SKYGN**
SKYGEN Dental Hub	**SKYGEN Dental Hub**
Clean Claim Timely Filing	**120 calendar days after the discharge for inpatient services or the Date of Service for outpatient services**

Electronic Claims Submission

Molina strongly encourages participating Providers to submit Claims electronically, including secondary Claims. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and Claims reach Molina faster.

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the SKYGEN Dental Hub.
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID SKYGN.

SKYGEN Dental Hub

The SKYGEN Dental Hub is a no cost online platform that offers a number of Claims processing features:

- Submit Dental Claims (2012 or newer ADA claim form)
- Correct/Void Claims.
- Add attachments to previously submitted Claims.

- Check Claims status.
    - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
    - Create and manage Claim Templates.
    - Create and submit a Claim Appeal with attached files.

Clearinghouse

Molina uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for Institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse.
- You should refer to the Molina Companion Guide for information on the response format and messages.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve the issue, the Provider should contact their Provider Services Representative for additional support.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 365 calendar days after the following have occurred: discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within 90 calendar days after the date of the final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate state and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the SKYGEN Dental Hub whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., for Dental Claims) and use electronic Payer ID number SKYGN. If applicable, for Members assigned to a delegated Medical Group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card.

Providers must bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed 30 calendar days from the change.

Required Elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina Provider Website at EDI, then Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate state from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are available on our Molina Provider Website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance Strategic National Implementation Process (SNIP) levels 1 to 5.

The following information must be included on every Claim:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- HIPAA-compliant CDT
- Total billed charges
- Place and type of service code

- Days or units as applicable (anesthesia Claims require minutes)
- Provider federal tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Rendering Provider information when different than billing
- Billing/pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), unit of measure and quantity for medical injectables
- E-signature
- Service facility location information

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the Claim.

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included in the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "Claim frequency codes." Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Molina will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice

(ERA). Without the original Claim number, adjustment requests will generate a compliance error and the Claim will be rejected.

Claim corrections submitted without the appropriate frequency code will be denied as a duplicate and the original Claim number will not be adjusted.

Corrected Claims Process

Participating Providers must submit Corrected Claims electronically via EDI or the SKYGEN Dental Hub.

All Corrected Claims must be sent within 365 calendar days of the most recently adjudicated date of the Claim and the original claim ID must be included in the remarks section.

Corrected Claims submission options:

- Submit Corrected Claims directly to Molina via the SKYGEN Dental Hub.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

Coordination of Benefits (COB) and Third-Party Liability (TPL)

Coordination of Benefits (COB) - Molina shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan, applicable state and federal laws, and applicable CMS guidance. If Molina is the secondary payer due to COB, Providers shall bill primary insurers for items and services they provide to a Member before they submit Claims for the same items or services to Molina for reimbursement. Molina will adjudicate the Claim based upon the primary explanation of benefits (EOB) submitted and pay for covered services up to the secondary liability based upon COB payment guidelines. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing

Medicaid Coverage for Molina Medicare Members

There are certain benefits that will not be covered by Molina Medicare program but may be covered by fee-for-service Medicaid. In this case, the Provider should bill Medicaid with a copy of the Molina Medicare remittance advice and the associated state agency will process the Claim accordingly.

After exhausting all other primary coverage benefits, Providers may submit Claims to Molina Medicare. A copy of the remittance advice from the primary payer must accompany the Claim or the Claim will be denied. If the primary insurance paid more than Molina's contracted allowable rate the Claim is considered paid in full, and zero dollars will be applied to Claim.

Reimbursement Guidance and Payment Guidelines

Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina utilizes a Claims adjudication system that encompasses edits and audits that follow federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Current Dental Technology (CDT) guidance published by the American Dental Association (ADA).
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than federal guidelines.
- Molina policies based on the appropriateness of health care and Medical Necessity.
- Payment policies published by Molina.

Claim Auditing

Molina shall use established industry claims adjudication and/or clinical practices, state, and federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon our request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that we paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Timely Claim Processing

A clean Claim is a Claim that has no defect, impropriety, lack of any required substantiating documentation as outlined in "Required Elements" above, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim.

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted Medical Group/IPA have agreed in writing to an alternate schedule, Molina will process the Claim for service as follows:

- 95 percent of the monthly volume of non-contracted "clean" Claims are to be adjudicated within 30 calendar days of receipt.
- 95 percent of the monthly volume of contracted Claims are to be adjudicated within 60 calendar days of receipt.
- 95 percent of the monthly volume of non-clean non-contracted Claims shall be paid or denied within 60 calendar days of receipt.

The receipt date of a Claim is the date Molina receives notice of the Claim.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with state and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. Dispute overpayment findings.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For Members with Commercial COB, Molina will provide notice within 270 days of the Claim's paid date if the primary insurer is a Commercial plan. A Provider may resubmit the Claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the Claim and pay or deny the Claim in accordance with Claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe

allowed Molina may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the overpayment.

Provider Claim Reconsiderations – Contracted Providers

Providers requesting a reconsideration of a Claim previously adjudicated must request such action within 120 calendar days of Molina's original remittance advice date or longer as stated in the Provider Agreement as the Provider Agreement would supersede.

Reconsiderations are defined as follows:

- Appeals - Written request for reconsideration of a Claim related to a complete denial of payment for services.
- Dispute - Written request for reconsideration of the amount paid on a Claim after the Claim has been adjudicated and payment has been remitted.

All Claim reconsiderations must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider Website and the SKYGEN Dental Hub. The form must be filled out completely in order to be processed. Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request
- The Claim number clearly marked on all supporting documents

All Appeals and Disputes must be submitted to Molina through one of the following channels:

- SKYGEN Dental Hub: SKYGEN Dental Hub/provider/login

Please Note:
The Provider will be notified of Molina's decision in writing within 60 calendar days of receipt of the Claims Reconsideration request.

Note: Corrected Claims are to be directed through the original Claim's submission process, clearly identified as a corrected Claim.

All questions pertaining to Claim reconsideration requests are to be directed to the Provider Contact Center at (855) 322-4079.

Provider Reconsideration of Delegated Claims – Contracted Providers

Providers requesting a reconsideration, correction or reprocessing of a Claim previously adjudicated by an entity that is delegated for Claims payment must submit their request to the delegated entity responsible for payment of the original Claim.

Balance Billing

Pursuant to law, Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the state or another payor is responsible for paying such amounts. The Provider is responsible for verifying member and benefit eligibility.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Fraud, Waste, and Abuse

Failure to report instances of suspected fraud, waste, and abuse is a violation of the law and subject to the penalties provided by law. Please refer to the Compliance section of this Provider Appendix for more information.

Encounter Data

Each Provider, capitated Provider, or organization delegated for Claims processing is required to submit Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Medical and pharmacy encounter data must be submitted weekly, and within 180 days from the date of service in order to meet state and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

Molina has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within 15 days from the rejection/denial.

Molina has created an 837D Companion Guide with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission.
- Second, Molina will provide a 277CA response file for each transaction.

MEDICARE MEMBER GRIEVANCES AND APPEALS

Distinguishing between Appeals Involving Provider Liability and Appeals Involving Member Liability

All Member liability denials are subject to the Member Appeals terms of this Provider Appendix described below. The Member will receive the appropriate denial notice with appeal rights (e.g., Integrated Denial Notice, Notice of Denial of Medicare Prescription Drug Coverage, Important Message from Medicare (IM), Notice of Medicare Non-Coverage (NOMNC), or Explanation of Benefits (EOB)). When Member liability is assigned, the Member Appeals process must be followed.

Disputes between Molina and a contracted Provider that do not result in an adverse determination or liability for the Member are subject to the Claims Appeals provisions of this Provider Appendix. The Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance of the Medicare Managed Care Manual specifically states that contracted Providers do not have appeal rights on their own behalf under the Medicare Member appeals process. Contracted Provider disputes involving plan payment denials are governed by the appeals and dispute resolution provisions of the relevant Provider Agreement. When Molina determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Agreement or Provider Manual, either administratively or by not providing the clinical information needed to substantiate the services requested, the contracted Provider is prohibited from billing the Member for the services unless Molina assigned Member liability and issued the appropriate notice with Member appeal rights. Additional information on the contracted Provider Claims appeal process can be found in the Claim Reconsideration subsection located in the Claims and Compensation section of this Provider Appendix.

Definition of Key Terms used in the Medicare Member Grievances and Appeals Process

Appeal: Medicare defines an appeal as the procedures that deal with the review of adverse initial determinations made by the Plan on health care services or benefits under Part C or Part D that the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving health care services or drug coverage (when a delay would adversely affect the Member's health), or on any amounts the Member must pay for a service or drug. These appeals procedures include a Plan reconsideration (Part C) or redetermination (Part D) (also referred to as a Level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

Authorized Representative: An individual appointed by the Member or authorized under State law to act on behalf of the Member in filing a Grievance or Appeal. An Authorized Representative has all of the rights and responsibilities of the Member. For Medicare, a Member may be appointed using the CMS Appointment of Representative Form found at cms.gov/cmsforms/downloads/cms1696.pdf.

Grievance: An expression of dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare Advantage Plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A Grievance does not include and is distinct from, an Appeal. Examples of a Grievance include but are not limited to the quality of care, aspects of interpersonal relationships such as rudeness of a Provider or Plan employee, waiting times for an appointment, cleanliness of contracted Provider facilities, failure of the Plan or a contracted Provider to respect the Member's rights under the Plan, involuntary disenrollment, Plan benefit design, the coverage decision or Appeals process, the Plan formulary, or the availability of contracted Providers.

Medicare Member Liability Appeals: How to File an Appeal

For Expedited Appeals: Call the Molina Contact Center

For Standard Appeals (non-Part D): Mail or fax a written Appeal to:

Molina Medicare of Ohio

Attn: Grievance and Appeals

PO Box 22816

Long Beach, CA 90801-9977

FAX: (562) 499-0610

For information on Part D appeals/redeterminations, please see the Medicare Part D section in this Provider Appendix.

Members and their Authorized Representatives (and treating Providers acting on their behalf) have 60 days from the date of the denial to file an Appeal. This timeframe may be extended for good cause.

Medicare Member Liability Appeals: Participating Provider Responsibilities in the Medicare Member Appeals Process

Appeals should include the Member's name, contact information, Member ID number, health plan name, the reason for appealing, and any evidence to support the request.

Providers can request Appeals on behalf of Members; however, if the Appeal is not requested by a treating physician, an Appointment of Representative (AOR) Form may be required. The AOR Form can be found online and downloaded at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

Please provide all medical records and/or supporting documentation with the Appeal request.

Expedited Appeals should only be requested if waiting the timeframe for a standard Appeal could jeopardize the Member's life, health, or ability to regain maximum function.

Medicare Member Liability Appeals: Timeframes

Appeal decisions are made as expeditiously as the Member's health condition requires and within regulatory timeframes.

Expedited Pre-Service (non-Part B, non-Part D drug)	72 hours
Standard Pre-Service (non-Part B, non-Part D drug)	30 calendar days
Standard Post-Service (Part C)	60 calendar days

Medicare Member Appeals: Further Appeal Rights

If Molina upholds the initial adverse determination, in whole or in part, for a Part C item or service (including a Part B drug), the Appeal will be forwarded to an Independent Review Entity (IRE). (For Part D upholds, the Member must request a review by the IRE.) The IRE is a CMS contractor independent of Molina. If the IRE upholds the initial adverse determination and the amount in controversy requirements are met, the Member may continue to an additional level of Appeal with an Administrative Law Judge (ALJ) or attorney adjudicator. Additional levels of Appeal are available to the Member if the amount in controversy requirements are met, including an appeal to the Medicare Appeals Council (MAC) and federal court.

Member Liability Appeals: Obtaining Additional Information about the Member Appeal Process

For additional information about Member Appeal rights, call Molina's Provider Contact Center toll free at (855) 322-4079, or 711, for persons with hearing impairments (TTY/TDD). A detailed explanation of the Appeal process is also included in the Member's Evidence of Coverage (EOC) (or Member Handbook), which is available on Molina's web site. If Members have additional questions, please refer them to Molina's Member Contact Center.

Medicare Member Grievances

A Member may file a Grievance verbally or in writing within 60 days of the event precipitating the Grievance.

Grievances are typically responded to by the Plan within 30 days. The Plan may also be allowed to take an extension under certain circumstances.

Medicare allows an expedited grievance only if the Plan diverts an expedited request for a coverage decision or Appeal to the standard timeframe or if the Plan takes an extension in making a coverage decision or deciding an Appeal (when allowed). These expedited grievances are decided within 24 hours.

Members may file a Grievance by calling Molina's Member Contact Center at (866) 472-4584 or by writing to:

Molina Medicare of Ohio
Attn: Grievance and Appeals
PO Box 22816
Long Beach, CA 90801-9977
Fax: (562) 499-0610